

CRITERIA FOR PRIOR AUTHORIZATION

Stelara® (ustekinumab)

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES The following drug requires prior authorization:
Ustekinumab (Stelara)

CRITERIA FOR PLAQUE PSORIASIS: (must meet all of the following)

- Patient must have a diagnosis of plaque psoriasis
- Must be prescribed by a rheumatologist or dermatologist
- Evaluation for latent tuberculosis (TB) with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- Patient must be a candidate for systemic therapy or phototherapy

CRITERIA FOR PSORIATIC ARTHRITIS (PSA): (must meet all of the following)

- Patient must have a diagnosis of psoriatic arthritis
- Must be prescribed by a rheumatologist or dermatologist
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Patient must be 18 years of age or older
- Patient has not taken another biologic agent (see attached table) in the past 30 days

LENGTH OF APPROVAL 6 months

Biologic Agents	
Generic Name	Brand Name
Abatacept	Orencia®
Adalimumab	Humira®
Alefacept	Amevive®
Anakinra	Kineret®
Certolizumab	Cimzia®
Golimumab	Simponi®
Infliximab	Remicade®
Natalizumab	Tysabri®
Rituximab	Rituxan®
Tocilizumab	Actemra®
Tofacitinib	Xeljanz®
Ustekinumab	Stelara®